CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
A. BU		1	A. BUILDING 07/14/20				
1.00000		B. WIN		TARRESON OF THE COLUMN	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.0.1	
NAME OF F	PROVIDER OR SUPPLIER			I	FADDRESS, CITY, STATE, ZIP CODE VEST 2ND STREET		
TODD DI	ICKEY NURSING A	ND REHABILITATION CENTER		1	ENWORTH, IN47137		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	FC	0000			
	Complaint IN000	_	'	,000			
	Complaint 111000	772421.					
	Complaint IN000	092421 Substantiated,					
		iciencies related to the					
	allegations are ci	ted at F282 and F328.					
	Survey dates: Ju	ly 13 and 14, 2011					
	-						
	Facility number:	000490					
	Provider number	: 155368					
	AIM number: 10	0291320					
	Survey team: Ar	nne Marie Crays RN					
	Census bed type:						
	SNF/NF: 55						
	Total: 55						
	Census payor typ	oe:					
	Medicare: 11						
	Medicaid: 36						
	Other: 8						
	Total: 55						
	Sample: 3						
	Sample. 3						
	These deficiencie	es also reflect State					
		accordance with 410					
	IAC 16.2.	accordance with 410					
	1/10.2.						
	Quality review co	ompleted 7/15/11					
			1				
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZZSO11

Facility ID:

000490

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155368		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2011				
NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 712 WEST 2ND STREET					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Cathy Emswiller							
F0282 SS=G	facility must be pro in accordance with plan of care.	ded or arranged by the ovided by qualified persons in each resident's written	E0292	It is the policy of Todd Disks	00/00/2011			
	based on intervi	ew and record review, the	F0282	It is the policy of Todd Dicker	9 08/08/2011			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155368 07/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 712 WEST 2ND STREET TODD DICKEY NURSING AND REHABILITATION CENTER LEAVENWORTH, IN47137 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nursing and Rehabilitation Center facility failed to ensure a resident received to ensure that services are respiratory treatments as ordered by the provided by qualified persons in physician, resulting in re-hospitalization accordance with each resident's for respiratory distress, for 1 of 1 residents written plan of care. Resident A no longer resides in the facility. A one reviewed with physician orders for time complete in-house facility respiratory treatments, in a sample of 3. audit was completed to ensure Resident A that all residents with ordered respiratory treatments were Findings include: receiving treatments as ordered and treatments were avilable in medication cart. Any resident 1. The clinical record of Resident A was found to not have ordered reviewed on 7/13/11 at 12:00 P.M. respiratory treatments or not Diagnoses included but were not limited receiving respiratory treatments as ordered, will have a clinical RN to, Mental Retardation. assessment and physician notification of any signs of The resident was readmitted to the facility respiratory distress. Facility will following hospitalization on 12/29/10. A seek emergency treatment if needed to nearest emergency hospital discharge summary, dated room.All nurses were re-educated 12/29/10, indicated: "...Diagnoses: 1. on facility policy of medication Acute aspiration pneumonitis 2. administration procedure Secondary left lower lobe pneumonia 3. including but not limited to use of emergency drug kit, and Multifactorial respiratory failure requiring contacting pharmacy for need of mechanical ventilation 4. Chronic medication from back-up obstructive pulmonary disease...Chronic pharmacy. DON/designee will dysphagia [difficulty perform weekly audit of availability of respiratory swallowing]...requiring...gastrostomy tube treatments for five residents (PEG) placement [feeding weekly. DON/designee will tube]...Medications on Transfer to the perform a weekly audit of five Facility:...DuoNeb nebulizer [breathing random observations of nurses administering respiratory treatment] therapy q [every] 4 hours. 13. treatments including Pulmicort nebulizer therapy q 8 hours...." documentation on medication administration record. The Quality A hospital respiratory treatment record, Assurance Committee will review the results of these audits on a dated 12/29/10, indicated Resident A last

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STATEMEN	li ´			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING 00			COMPLETED	
155368			B. WING 07/14/2011					
			D. WI		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	S.			EST 2ND STREET			
TODD DI	ICKEY NURSING A	ND REHABILITATION CENTER		1	NWORTH, IN47137			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	received a DuoN	eb and Pulmicort			monthly basis for changes o	r		
	respiratory treatr	nent at 3:38 P.M.			updates, as indicated. Any			
					non-compliance will be addr			
	Admission order	s, dated 12/29/10,			by the administrator/DON th 1:1 re-education and/or	lough		
		eb mini neb [nebulizer] Q			disciplinary action.			
		cort nebulizer Q 8			,,,			
	1 - 1	con neounzer Q o						
	[hours]."							
	Nursing Progress	s Notes included the						
	Nursing Progress Notes included the following notations: 12/29/10 at 8:00 P.M.: "Resting quietly							
	abed. I have checked rsd [resident] frequently. [No] resp [respiratory]							
	distress"	resp [respiratory]						
	distress							
	12/29/10 at 11:00 P.M.: "Res [resident]							
	placed on her Rt	sideNo resp distress						
	noted."	1						
	12/30/10 at 12:30	0 A.M.: "Res						
	experiencing resp	p. difficultyO2 sat						
	[saturation] 50%	on humidifier 28% via						
	trach at 3L/m. Re							
		actioned per trach12:40						
		ohysician] notified. Order						
	· · ·	es transported to [name of						
	hospital] in [nam							
	i nospitarj ili [ilalii	icj amoulance.						
	A Respiratory Tr	eatment Record, undated,						
		oneb mini neb Q 4						
	[hours] 6a-10a-2	~						
	Pulmicort nebuli							
	oa-4p-12am. Tr	ne treatment record was						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368		(X2) MU A. BUII B. WING	LDING	NSTRUCTION 00	(X3) DATE (COMPL 07/14/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI)	D. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					ST 2ND STREET		
TODD D	ICKEY NURSING A	ND REHABILITATION CENTER		LEAVEN	NWORTH, IN47137		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
1710	+	ated no treatments were	+	mo	·		DATE
	administered.	ated no treatments were					
	Documentation	was lacking in the clinical					
	record that the re	esident received either the					
	Duoneb or Pulm	icort breathing					
	treatments.						
	1	45 P.M., during interview					
	with the Director of Nursing [DON], she						
	indicated since the resident was not						
	admitted to the facility until 5:30 P.M.,						
	1	atment medications					
		been delivered by the					
	1 ^	3:00 A.M. The DON					
	1	ility did have a back-up					
		hat the nurse would have					
	had to tell the ph	-					
	medications she would want delivered						
	immediately.						
	2. On 7/14/11 at	10:00 A.M., the DON					
		rent facility policy on					
	1 ^	rim/Stat/Emergency					
	1 ^	ed May 2010. The policy					
	1	ility should immediately					
	1	when Facility receives					
	1 '	n/Provider a medication					
	order that may re						
	interim/stat/eme	rgency delivery. 2. If a					
	necessary medic	ation is not contained					
	within Facility's	interim/stat/emergency					
	supply, and Faci	lity determines that an					
	interim/stat/eme	rgency delivery is					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368	(X2) MUI A. BUILE B. WING		00	(X3) DATE S COMPL 07/14/2	ETED
NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER				712 WE	DDRESS, CITY, STATE, ZIP CODE ST 2ND STREET IWORTH, IN47137		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	With Pharmacy t interim/stat/emer medication(s) in delivery or a spe or For delivery b the medication to delivered by a TI ensure timely rec	rgency supply an earlier scheduled cial delivery, as required, y contract courier, or For be dispensed and nird Party Pharmacy to					
F0328 SS=G	proper treatment a special services: Injections; Parenteral and en	ostomy, or ileostomy care; e;					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155368 07/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 712 WEST 2ND STREET TODD DICKEY NURSING AND REHABILITATION CENTER LEAVENWORTH, IN47137 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on interview and record review, the F0328 It is the policy of Todd Dickey 08/08/2011 Nursing and Rehabilitation Center facility failed to ensure a resident with a to ensure that residents receive diagnosis of pneumonia and with a recent proper treatment and care for the feeding tube insertion, received breathing following special services: treatments as ordered, and received injections, parenteral and eternal fluids, colostomy, ureterostomy, assessment of breath sounds other than at or ileostomy care, tracheostomy admission, resulting in re-hospitalization care, tracheal suctioning, for respiratory distress, for 1 of 1 residents respiratory care, foot care and reviewed with physician orders for prostheses. Resident A no longer resides in the facility. A one time respiratory treatments, in a sample of 3. complete in-house facility audit Resident A was completed to ensure that all residents with ordered respiratory Findings include: treatments had respiratory assessments per facility policy in coordination with respiratory 1. The clinical record of Resident A was treatments.All nurses were reviewed on 7/13/11 at 12:00 P.M. re-educated on facility policy on Diagnoses included but were not limited respiratory assessment in coordination with administration to, Mental Retardation. of respiratory treatments. DON/designee will perform a The resident was readmitted to the facility weekly audit of five random following hospitalization on 12/29/10. A observations of respiratory assessments to ensure hospital discharge summary, dated compliance with policy. The 12/29/10, indicated: "...Diagnoses: 1. **Quality Assurance Committee will** Acute aspiration pneumonitis 2. review the results of these audits Secondary left lower lobe pneumonia 3. on a monthly basis for any change or updates, as indicated. Multifactorial respiratory failure requiring Any non-compliance will be mechanical ventilation 4. Chronic addressed by the obstructive pulmonary disease...Chronic administrator/DON through 1:1 dysphagia [difficulty re-education and/or diciplinary action. swallowing]...requiring...gastrostomy tube (PEG) placement [feeding tube]...Medications on Transfer to the Facility:...DuoNeb nebulizer [breathing treatment] therapy q [every] 4 hours. 13.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155368	A. BUII		00	07/14/2011	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0771472	011
NAME OF P	PROVIDER OR SUPPLIER			l	ST 2ND STREET		
TODD DI	CKEY NURSING AI	ND REHABILITATION CENTER		l	NWORTH, IN47137		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Pulmicort nebuli	zer therapy q 8 hours"					
	dated 12/29/10, i received a DuoN respiratory treatn Admission orders included: "Duone						
	Data Collection a 12/29/10 at 5:30 "Admitted from hospital]Respir Sounds: Diminist Inability to breat! YesTrach: [yes]						
	following notation 12/29/10 at 8:00 abed. I have check frequently. [No] distress" 12/29/10 at 11:00 placed on her Rt noted."	P.M.: "Resting quietly eked rsd [resident] resp [respiratory] P.M.: "Res [resident] sideNo resp distress					
	12/30/10 at 12:30) A.M.: "Res					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
	155368			B. WING 07/14/2011				
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
				1	EST 2ND STREET			
TODD DI	ICKEY NURSING AI	ND REHABILITATION CENTER		LEAVE	NWORTH, IN47137			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
IAG		·	+	IAG			DATE	
		p. difficultyO2 sat on humidifier 28% via						
	1 -							
	trach at 3L/m. Re							
		actioned per trach12:40						
	_ ^	physician] notified. Order						
		es transported to [name of						
	hospital] in [nam	ie] ambulance."						
	Documentation v	was lacking in the clinical						
	Documentation was lacking in the clinical record that the resident received either the							
	Duoneb or Pulmicort breathing treatments.							
	treatments.							
	An EMS [emerge	ency medical service]						
		nt, dated 12/30/10 and						
	1 ^	ed: "Treatment by						
	· ·	x 2, Atrovent x 1"						
		,						
	A hospital nursin	g patient record, dated						
	12/30/10 at 1:55	A.M., indicated, "Chief						
	complaint: Resp	Distress/Asthma/URI						
	[upper respirator	y infection]SOB [short						
	of breath] [Yes]	.Mild Distress						
	[Yes]Crackles:	Bil [bilaterally]"						
	A Emergency Ph	ysician Record, dated						
	12/30/10 at 3:20	A.M., indicated, "Chief						
	complaint: dyspr	nea [shortness of						
	breath]Treatme	ent bronchodilator						
	therapy, treatmer	nts given: 3"						
	_	ervation Summary," dated						
	· ·	ed, "This individual						
	had been dischar	ged to [name of facility]						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	155368			LDING	00	COMPLETED 07/14/2011	
		100000	B. WIN		A DDDEGG CITY CTATE 7ID CODE	0771472	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EST 2ND STREET		
TODD D	ICKEY NURSING AI	ND REHABILITATION CENTER		1	NWORTH, IN47137		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	+	I was contacted in the	+	IAG			DATE
		ours of 12/30/10 by the					
		nat she was poorly					
	1	ficantly hypoxemic [short					
		ngested. Reports from					
	EMS and from the	-					
		indicated that she					
	_	ant suctioning but after					
		formed she appeared to					
	1	e statusThe patient's					
		ed no new infiltrates"					
	On 7/13/11 at 1:4	45 P.M., during interview					
	with the Director	of Nursing [DON], she					
	indicated since th	ne resident was not					
	admitted to the fa	acility until 5:30 P.M.,					
	the breathing trea	atment medications					
	would not have b	een delivered by the					
	pharmacy until 3	:00 A.M. The DON					
		ility did have a back-up					
		at the nurse would have					
	had to tell the ph	-					
		would want delivered					
	1	e DON indicated she did					
		nedications were in the					
	1	kit [EDK]. The DON					
		dent's lung sounds would					
		ed before and after					
	receiving the bre	athing treatments.					
	On 7/14/11 at 10	:00 A.M., the DON					
		g of the contents in the					
	1 -	ontents did include					
	Albuterol for the	DuoNeb treatment. The					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER TODD DICKEY NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG DON indicated she inserviced nursing on 7/13/11 regarding receiving medications from the back-up pharmacy. This Federal tag relates to Complaint IN00092421. 3.1-47(a)(6)	l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155368	(X2) MULTIPLE CO A. BUILDING B. WING	00	I	E SURVEY PLETED 2011
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DON indicated she inserviced nursing on 7/13/11 regarding receiving medications from the back-up pharmacy. This Federal tag relates to Complaint IN00092421.		ICKEY NURSING A	ND REHABILITATION CENTER	712 WE	EST 2ND STREET	DE	
7/13/11 regarding receiving medications from the back-up pharmacy. This Federal tag relates to Complaint IN00092421.	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETION
	IAU	DON indicated s 7/13/11 regarding from the back-up This Federal tag IN00092421.	he inserviced nursing on g receiving medications pharmacy.	IAG	DETECTION 1		DAIE